Nooksack Community Health Plan
P.O. Box 157 Deming, WA 98244
2510 Sulwhanon Drive Everson, WA 98247
Phone: (360) 966-2106 ✦Fax: (360) 922-7027

Community Health Program Benefits

To allow the tribe to account for and process payment for **medical and dental services**, the following procedures are required:

- The enrolled Nooksack Tribal member shall notify the Nooksack Tribe's Community Health Fund Program and obtain prior authorization of services prior to their **Medical and Dental Service appointment.**
- The enrolled Nooksack Tribal member shall provide the name of their health care provider along with phone number, address, type of medical/dental services requested and the date the appointment is scheduled. **Treatment plans must be approved prior to scheduled appointments**.
- The Community Health Fund staff shall coordinate with the NIT Tribal member and the medical and/or dental service vendor to obtain costs.
- Community Health fund staff shall utilize any patient health care coverage such as; Health Insurance, State or Federal Agency programs which allow more NIT Tribal members to be served.
- The patient's health care provider shall submit an invoice to the Nooksack Indian Tribe's Community Health Fund Program for the processing of payment by the NIT Accounting Office.
- The Community Health Fund program staff will notify the enrolled NIT Tribal Member of the payment of the medical and/or dental invoices.

- All enrolled Nooksack Tribal Members shall complete the CHF application along with proof of medical necessity and proof of dental services needed.

Service Delivery Plan

The Tribal Council provides the following Eligible Medical and Dental Services with Maximum allowable benefits identified below for qualifying Members, pursuant to Title 99:

- **Vision Care**
  - Standard eye exam $150.00
  - Frames: $300.00
  - Total Package $450.00 **per calendar year**.
- **Hearing Aids**
  - Hearing Aids per unit $500.00.
  - Repairs $300.00 max
- **Durable Medical Equipment**
  - Wheelchairs $5000.00 max
  - Max co-pay per person $1000.00 max
- **Durable Medical Supplies**
  - $500.00 per person/per year max
- **Chiropractic/Acupuncture/ Medical Message**
  - 10 Visits per person per calendar year
- **Orthotic/Diabetic Shoes**
  - Orthotic support/Diabetic shoes $400.00 max per calendar year.
- **Dental/Dentures**
  - Complete Upper/Lower Dentures $5000.00
  - Partial Dentures $1,400-$1,600.00
  - Denture Flipper $350.00-$600.00
  - 3 unit Anterior Bridge $3,000-$3,500.00
  - Implants $3,500.00 max
  - Crowns $1,000.00 max
  - Braces $2000.00 max
  - One time only due to limited funds.
- **Lifeline**
  - Emergency Life-saving monthly services $27.00-$40.00.

The Community Health Fund (CHF) was developed to meet the unmet needs of Nooksack tribal members. The following list was developed as a list of items that are aimed at meeting significant needs beyond the current level of services offered. ***Applications must be submitted before any types of services are done. Applications will be approved once it has been reviewed and all information has been submitted. Please make sure to sign and date the application.***

AREA ONE: Vision Care
(Resources available once per calendar year).

Standard Eye Exam: $150.00
Frames: $300.00
Total Vision Package: $450.00

AREA TWO: Hearing Aids
(Resources available one time only due to limited funds).

Hearing Aids per unit $500.00
Hearing aids repair: $300.00 max
Total Package: $2000.00

AREA THREE: Orthotic & Diabetic Shoes
(Resources available once per calendar year).

Orthotic & Diabetic Shoes: $200.00
Purchase of up to 3 pairs of insoles $120.00
Total Orthotic & Diabetic Shoes Package: $400.00

AREA FOUR: Lifeline.
(Resources available on a case by case basis).
Emergency Life-Saving Monthly services
Total Package: $27.00-$40.00

AREA FIVE: Dental/Dentures
(Resources available one time only due to limited funds. Requests will be reviewed on case by case basis).

Complete Upper/Lower Dentures: $5,000.00
Partial Denture: $1,400.00 to $1,600.00
Denture Flipper: $350.00 to $600.00
3 Unit Anterior Bridge $3,000.00 to $3,500.00
Implants: $3,500.00 max
Crowns: $1,000.00 max
Braces: $2,000.00 max

AREA SIX: Chiropractic/Medical Massage/Acupuncture.
(Resources available once per calendar year)

Chiropractic: 10 visits per calendar year
Medical Massage: 10 visits per calendar year
Acupuncture: 10 visits per calendar year

Contact: Jeff Bailey
Nooksack Health Center 360-966-2106 ext. 2112
Email: jbailey@nooksack-nsn.gov

COMMUNITY HEALTH FUND APPLICATION

Today's date: **Signature at the bottom**

MEMBER INFORMATION

Member's last name: First: Middle: ❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.

Marital status (circle one)
Single / Mar / Div / Sep / Wid

Is this your first CHF request? ❑ Yes ❑ No

If no, what have you been funded for previously?

Enrollment Number:

Birth date: / /

Age:

Sex: ❑ M ❑ F

Street address:

Social Security no.:

Phone Number: ( )

P.O. Box: City: State: ZIP Code:

Occupation: Employer:

Employer phone no.: ( )

Category of Services Requested:

❑ Vision ❑ Hearing Aid ❑ Orthotic & Diabetic Shoes ❑ Lifeline/wheelchair ❑ Dentures/ Partials/Bridge ❑Braces ❑Implants ❑Crown

❑ Chiropractic/medical massage/acupuncture

ALTERNATE INSURANCE INFORMATION

(Please provide a copy of your insurance information)

Person who has alternate insurance: Birth date: / / Address (if different): Phone Number: ( )

Occupation: Employer: Employer address: Employer phone number: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's name: Subscriber's S.S. no.: Birth date: / / Group no.: Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

PROVIDER INFORMATION

Provider Name: Address: Phone Number: ( ) Fax Number: ( )

Please attach the Provider's referral or prescription to application and fax to the attention of Community Health Fund office at 360-922-7027.
If you have any questions please contact: **Jeff Bailey at 360-966-2106 or via email at jbailey@nooksack-nsn.gov.**

The above information is true to the best of my knowledge. I authorize Contract Health Staff to verify all information as stated. I understand that I am financially responsible for any balance. I also authorize Nooksack Health Clinic to release any information required to process my claims.

X
Signature

X
Date